

"Still
The Second
Best Thing
About Payday"

The NIH Record

Healy Confirmed, To Emphasize Human Talent

The following is a statement made by Dr. Bernadine P. Healy before the Senate committee on labor and human resources on Mar. 14.

The confirmation hearing, which lasted 2 hours, began with remarks by committee chairman Sen. Edward Kennedy, who emphasized that the excellent service of NIH acting director Dr. William F. Raub was the "silver lining" that redeemed the prolonged interim between official NIH directors.

Healy was confirmed as the 13th NIH director on Mar. 21 and is expected to be sworn in prior to Apr. 9, when House budget hearings for NIH begin.

The NIH is a national treasure. The philosopher-essayist of modern medicine, Lewis Thomas, put it well: As institutions for human betterment go, NIH "is a standing proof that, at least once in a while, government possesses the capacity to do something unique, imaginative, useful and altogether right."

The NIH has been driven these past 100 years by the mission to acquire new knowledge of human disease, and to do so for the betterment of all our citizens. With that mandate the NIH has nourished a science base that reaches out to more than 1,700 universities and research institutions, and enlists the labors of more than 100,000 people working at some level on the many NIH-funded



Dr. Bernadine P. Healy

activities. The strong federal support of biomedical research through the NIH system has enabled science to flourish largely unfettered, has promoted diversity of ideas, and has fostered healthy competition and necessary cooperation. This has been done largely by allowing the many research institutions inside

(See HEALY, Page 6)

Much Ado About Magnet

56-Ton Diagnostic Device Finds Home at NIH

By Carla Garnett

Weighing in at 56 tons, transported 500 miles from Schenectady, N.Y., by a specially designed truck and lifted by crane into a newly built, copper-walled mini arena, the arrival of NIH's newest acquisition definitely attracted attention. But that's what magnets are made to do. And NIH has just installed a mammoth 4.0 Tesla magnet in the Clinical Center's backyard.

"It has the highest magnetic field for use in human studies," said Dr. Robert Balaban, chief of NHLBI's Laboratory of Energetics. "It is three times the size of the magnets we have been using for animal studies. These magnets are 33 centimeters in diameter compared to this new one, which is about one meter in diameter."

NIH is only the third site in the United States to earn the right to house such a magnet, which is used to diagnose illnesses, or body function disorders, noninvasively. The higher the magnetic field of the magnet, the higher resolution images can be produced faster. Similar size magnets are located at research centers at the University of Alabama and the University of Minnesota.

(See MAGNET, Page 2)

Profiles of the NIH Directors

By Dr. Victoria A. Harden

First of two-part series

Dr. Bernadine Healy will be NIH's 13th director and the first woman to lead the agency. As she prepares for the challenges that await her, NIH'ers may wonder about the directors who preceded her. Who were they and how did they contribute to NIH's position of world preeminence in biomedical research?

Their origins were diverse: three were born in Virginia, two each in Pennsylvania and New York, and one each from North Carolina, Indiana, Ohio, Colorado, and Michigan. Half were born in the 19th century and half in the 20th; all six born this century are still living. Two received their medical training at New York University, two at the University of Virginia, and two at the University of Michigan. The others came from a variety of institutions. Their average age upon becoming director was 46. The youngest was only 27 and the oldest was 58.

Dr. Joseph J. Kinyoun, 1887-1899

The first director, Dr. Joseph J. Kinyoun, could hardly have imagined that his one-room
(See DIRECTORS, Page 7)



A 56-ton magnet, a noninvasive diagnostic tool used in magnetic resonance imaging, was recently transported to NIH from Schenectady, N.Y., by a specially built steel-frame truck (far l). Installation of the device into a newly constructed annex of Bldg. 10 required the aid of a crane and several workmen.

MAGNET

(Continued from Page 1)

NIH and the other two facilities are about neck and neck in the race to pioneer in nuclear magnetic resonance (NMR), a relatively young field of study that, while conceptualized since the early 1970's, only came into its own as a biomedical research tool in the last decade.

Balaban credits NHLBI director Dr. Claude Lenfant with the successful lobbying of Congress that put NIH on the cutting edge of research in NMR.

"We are pleased and proud to be one of only three facilities in the U.S. to have this type of magnetic imager," said Lenfant. "It will allow intramural scientists to view very small blood vessels, to measure compounds in the body that could not be measured before, to do tracer studies of metabolic rates in body tissues, and to carry out many other investigations that would not be possible otherwise."

Though constructed by Oxford Instruments, the \$8.3 million magnet was designed and built by General Electric. In the NIH project, GE, which offered approximately \$5 million to the NIH magnet project in a cost-share arrangement, gains needed access to approved patient-care settings for extensive clinical testing of its high resolution system. NIH spent the remaining \$3.3 million that landed the instrument here.

"I want to emphasize that this is a national center and we're encouraging interested extramural research facilities to make use of the magnet," said Balaban.

Aside from fiscal and political maneuvering, much logistical preparation also went into the magnet's journey to NIH.

Robert Alexander, the Division of Engineering Services project officer who oversaw the construction campaign, said the project has averaged 35-40 workers daily since December. Four months earlier, ground was broken for the new magnet room located on the southwest corner of Bldg. 10, adjacent to the In Vivo NMR Research Center. No existing building could be used because the magnet's powerful force wipes out computer memory and interferes with computer monitors and other equipment. The new 1,100-square-foot room is completely lined with copper—about \$25,000 worth—which blocks radio and television airwaves that could disrupt function of the system.

In addition, the magnet's voyage from Schemm Hall had to be specially timed, Alexander said. Most states restrict the transport of materials weighing over a certain tonnage. NIH's magnet was too heavy to travel on highways during normal rush hours.

Alexander also had to map out the magnet's campus route. NIH has only one road—Center Dr.—that can safely accommodate 56 tons plus truck weight.



Workmen attach crane cables to the 56-ton magnet to help position it safely on a steel dolly. The dolly was then rolled into the In Vivo NMR Research Center annex.

Despite the challenges the magnet program has faced in its initial stages, the machine should be fully functional in the next few months according to Balaban. "We hope to begin testing normal volunteers in the next few months," he said. "Then, by September, we'll start evaluating patients." □



Dr. John Dickson (l) and George Potter of DCRT's Computer Center Branch pull the symbolic plug on an old mainframe friend—DECsystem-10—which "retired" after 22 years of faithful (and reliable) service. The Feb. 28 shut-down featured a cake, refreshments, and tours of the facility, along with exhibits from the DEC-10's history. Already in operation is its replacement, the Convex C240 supercomputer, which offers upgraded biomedical computing capabilities to the NIH user community.

Study Requires Women

Women ages 56-70 are needed to participate in studies of endocrine secretion in healthy adults. All participants will be reimbursed for their time. Volunteers must be in good health and on no medications. If interested, call Dr. David Michelson of NIMH's Clinical Neuroendocrinology Branch, (301) 496-1891. □

Corrections

A story on gene therapy for cancer in the Feb. 5 issue of the *Record* was missing a key phrase in the next-to-last paragraph. With the corrected words italicized, the paragraph should have read: "At the tumor site, tumor necrosis factor (TNF) appears to work by cutting off the developing blood supply in that region. By using tumor-infiltrating lymphocytes to target the tumor and carry the TNF gene directly to the tumor site, the scientists hope to maximize *the gene's benefit and also minimize* the potential toxicity that could result if TNF were distributed throughout the body."

In a picture caption on p. 6 of the Mar. 19 *Record*, the individual identified as Dr. Marilyn G. Farquhar is actually DRG's Dr. Anne Clark; Farquhar's photo will run in a future issue of the *Record*. □

The NIH Record

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NIAMS Marks Fifth Anniversary With Lecture On Immunogenetics, Autoimmune Diseases

By Lauren Ward

In 1965 a young physician, Dr. Hugh McDewitt, and a colleague from Israel, Dr. Michael Sela, injected two genetically different strains of mice with the same synthetic polypeptide. One strain reacted with vigorous production of antibodies; the other responded with only a trickle. This was one of the first systematic studies that demonstrated a genetic control over the function of the immune system. McDewitt's pioneering work in the field, now called immunogenetics, has culminated in our current understanding of the major histocompatibility complex (MHC), a cluster of genes on chromosome 6 that regulates the body's immune defenses. The genes stamp the outside of each cell with a unique set of tissue markers (known as human leukocyte antigens—HLAs—or histocompatibility markers).

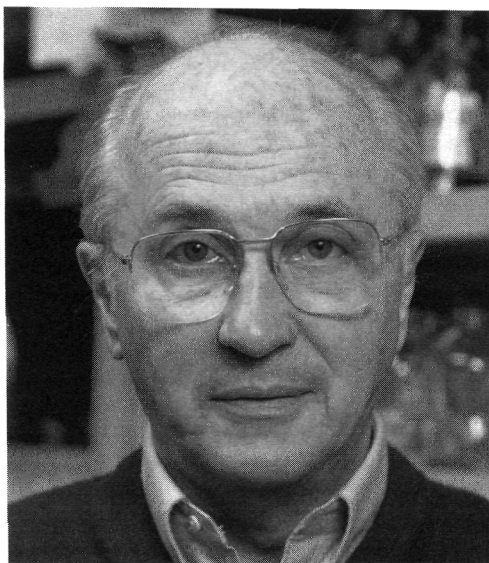
Studies on the MHC complex by McDewitt and others have yielded considerable insights into a group of disparate disorders called autoimmune diseases, in which the immune system goes awry and attacks the body's own tissues. Autoimmunity is an aspect of many disorders that are of great importance to the research programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases. In a celebration of the institute's fifth anniversary, McDewitt will deliver a presentation on "The Role of MHC Class II Molecules in Autoimmune Diseases." His lecture will be given on Apr. 17, from 2 to 3 p.m. in Lipsett Amphitheater, Bldg. 10. A reception will follow the lecture in the area just outside of the amphitheater.

"We are truly delighted to have Dr. McDewitt speak to us on this special occasion," says Dr. Lawrence E. Shulman, NIAMS director. "His seminal research cuts across the major disease areas of this institute."

McDewitt is internationally renowned for his work on the immunogenetics of several autoimmune diseases such as rheumatoid arthritis and type I diabetes. For 25 years, he has been affiliated with Stanford University, where he was chairman of the department of microbiology and immunology from 1986 to 1990. Currently, McDewitt is a professor of microbiology and immunology and medicine there.

The large MHC gene complex is divided into several regions. Markers coded by genes in the region called MHC I are generally found on every cell with a nucleus. Markers coded by MHC II genes normally lie on specific cells of the immune system. Both sets of molecules are necessary for the body's immune system to ward off an onslaught of invading organisms.

Some autoimmune diseases are found more



Dr. Hugh O. McDewitt

often in people with a particular class I or class II MHC marker, strongly implicating these markers in the disease. A most striking association is that of ankylosing spondylitis (a form of spinal arthritis) with the marker HLA-B27, which is found in more than 90 percent of individuals diagnosed with the disease. Other markers have been significantly associated with rheumatoid arthritis, systemic lupus erythematosus, the skin disease pemphigus vulgaris, and many additional diseases.

The MHC marker plays just one part. "Clearly, to develop an autoimmune disease, you must encounter a critical environmental factor," says McDewitt. Many patients with an HLA-B27 associated arthritic condition called Reiter's syndrome develop the disease after becoming infected with the bacterium *Shigella flexneri*. Scientists suspect that exposure to bacteria, viruses, or certain medications may trigger other autoimmune diseases.

Research at the molecular level suggests how the connection between MHC marker and

infectious agent may derail the immune response. To start, an MHC-labeled cell must encounter an intruder. The germ is engulfed and its proteins and other constituents digested. In what is called antigen processing, digested fragments such as peptides are ferried to the outside of the cell, which is coated with MHC markers. There, a peptide can nestle in the cleft formed by the external portion of an MHC molecule. When the combination of peptide and MHC marker is seen by another immune cell called a T cell, the T cell starts waging a full-fledged immune response. Problems may arise when the combination of MHC marker and peptide resembles one of the body's own molecules. If a masquerader sets off a normally silent T cell, trouble ensues. The body attacks one of its own proteins and loses what researchers call self-tolerance.

Over the last decade, scientists have teased apart the complex molecular aspects of the immune response and found relationships between specific MHC markers and more than 40 autoimmune diseases. This knowledge, along with further discoveries, could lead to improvements in both the diagnosis and treatment of these disorders. "In the future, if you have a patient who has recently developed stiff knees and ankles, you could do testing for specific genetic markers and predict whether that patient risks serious arthritic disease," says McDewitt. Early diagnosis could then lead to earlier treatment.

One of the most likely targets for treatment of an autoimmune disease is the MHC molecule. "The idea is to make a substance that binds well to the MHC molecule but that isn't seen by your T cells," says McDewitt. Already, researchers have used such blocking agents in studies in which animals are induced to develop experimental allergic encephalitis (EAE), a disease that resembles multiple sclerosis in humans. Animals first given the blocking drug and then immunized for EAE do not develop the disease. However, when animals already manifesting the disease are given this drug, they do not recuperate. According to McDewitt, "The question is still if you can take someone with an autoimmune illness and stop the disease using an MHC blocking peptide."

For McDewitt, the field of autoimmunity remains wide open. "We're discovering a lot of new genes near the MHC region that have to do with antigen processing," he says. Tools like transgenic animals and the polymerase chain reaction should speed research. McDewitt is confident, but realistic, about developing a magic bullet for any autoimmune disease. "Ten years down the line, I can imagine that we'll have developed a blocking compound against a human MHC molecule," he says. "From that point, it's going to take 5 to 10 years to bring it through clinical trials." □

The Mission of NIAMS

The National Institute of Arthritis and Musculoskeletal and Skin Diseases leads and coordinates the federal biomedical research efforts in rheumatic diseases such as rheumatoid arthritis, lupus, scleroderma, osteoarthritis, and Lyme disease; in bone biology and bone diseases such as osteoporosis; in heritable disorders of connective tissue; in orthopedics and biomechanics; in sports medicine; in muscle biology; and in skin diseases such as psoriasis, vitiligo, and pemphigus.

The NIAMS was established by the secretary, DHHS, on Apr. 16, 1986, under the provisions of P.L. 99-158, the Health Research Extension Act of 1985.

NICHD Examines Seldom-Studied Women's Disease

By Anne Blank

It is at least as old as ancient Greece, when it was first described by Hippocrates.

It is something that, at least in one of its most common forms, will affect most women one or more times in their lives.

It is the most common complaint leading to gynecological visits and causes countless hours of distress and suffering for large numbers of women.

It is vulvovaginitis.

Vulvovaginitis—inflammation of the vagina and vulva—is a complex disease that occurs when infection, disease or other trauma changes the composition of the microbial flora in the vagina, leading to an overgrowth of "bad" bacteria or fungi over the normal bacteria that are always present. Any of a number of infections, either fungal, bacterial or viral, can result in vulvovaginitis.

Other factors that may change the vaginal flora and thus lead to vulvovaginitis include antibiotics; douching; irradiation; surgery; cysts; polyps; oral contraceptives; systemic diseases such as uncontrolled diabetes; immunosuppressive diseases such as AIDS; spermicides; and foreign bodies left in the vagina such as an intrauterine device (IUD) filament, a diaphragm or tampons.

With so many potential causes, therapy for vulvovaginitis is understandably complex and variable. While an anti-yeast suppository may clear up a yeast-related vulvovaginitis, it will not help a bacterial or viral infection. Furthermore, what may work for one woman may not work for another.

In an effort to clarify current knowledge of the causes and treatments of vulvovaginitis, experts in the fields of obstetrics/gynecology, bacteriology and mycology, dermatology, oncology, and biochemistry met recently at an NIH conference, "Vulvovaginitis—Causes and Therapies," cosponsored by NICHD and the International Society for the Study of Vulvar Disease.

Although vulvovaginitis has affected women for centuries, only recently has it started receiving significant attention from researchers. In fact, the first time medical investigators met to discuss the disease was in 1984. "With this new resurgence of interest in women's health, we've started to pay much more attention to what we are funding," said Dr. Florence Haseltine, director of NICHD's Center for Population Research and a cochair of the conference. "Now we try to stimulate interest in areas that directly relate to women's health as women see it, and not just what researchers and other physicians think are interesting."

In reproductive-age women, the most common cause of vulvovaginitis is bacterial

vaginosis (BV), which has also been called *Gardnerella* vaginitis, nonspecific vaginitis, and *Corynebacterium* or *Haemophilus* vaginitis. Symptoms may include increased discharge and a bad vaginal odor, although more than half the women with BV may be clinically asymptomatic. Because of the large number of asymptomatic cases, some clinicians recommend standard screening procedures. "Just as we do a Pap smear annually, I think we should screen for BV annually," said Dr. Jessica Thomason, professor of ob/gyn at the University of Wisconsin.

Although the specific cause of BV remains unknown, some theories suggest that it may be the result either of a change in the vaginal flora or endogenous infection. *Gardnerella vaginalis* and other organisms implicated in BV can inhibit Lactobacilli, the so-called "good" bacteria that normally inhabit the human vagina.

Methods of contraception also can affect a woman's risk for developing BV. In a Scandinavian study cited by Dr. Per-Anders Mardh, professor of bacteriology at Uppsala University, Sweden, researchers found a positive correlation between BV and IUD use, which may induce changes in the vaginal flora. IUD use also may increase the risk of ascending infection by sexually transmitted diseases (STDs) and other genital infections, which can lead to pelvic inflammatory disease, a leading cause of infertility in women. No correlation was found between BV and barrier

or oral contraceptives.

Most cases of BV respond well to oral antibiotic treatment. Recurrent disease, however, is a common problem. In such cases, treatment of sexual partners may be indicated, although the Centers for Disease Control does not currently recommend treatment of sexual partners as a standard practice when treating women with BV.

Two common viral causes of vulvovaginitis are human papillomavirus (HPV), which causes genital warts, and herpes simplex virus. HPV infection may be either subclinical or clinically apparent with visible warts in the genital area, as well as itching, pain or bleeding. Recent studies indicate that a large percentage—15 to 40 percent—of the female population may be infected with HPV, but have no clinical symptoms.

By far the most serious complication of HPV infection is vulvovaginal cancer. Of the 13 HPV subtypes that have been isolated in the genital area, HPV 16 and 18 are associated with malignant genital lesions. Because of this risk, genital warts should be diagnosed and treated immediately. "Diagnostic tests are only as good as you are in doing them," said Dr. Marilynne McKay, chief of dermatology at Grady Memorial Hospital in Atlanta. "Biopsy should be performed on any suspicious lesions."

While invasive cancer of the vulva used to afflict mainly older women, the spread of HPV infection among younger women is changing its demographics. Vulvar cancer now is occurring increasingly in younger women, said Dr. Kenneth Hatch, director of

Blessley Joins Blood Bank Hall of Fame



David Blessley of DCRT's Data Management Branch recently became a member of the NIH Blood Bank's Hall of Fame by donating his 100th unit of blood. He has been at NIH for 27 years as a computer systems analyst and gave his first donation to the Clinical Center on Feb. 10, 1966. His 101st donation is scheduled this month. Presenting his certificate is Janet Pavel, chief nurse in the Clinical Center's department of transfusion medicine.

gynecologic oncology at the University of Arizona School of Medicine.

Although HSV is no longer thought to have a primary role in the development of vulvovaginal cancer, some experts believe that it may be influential when present with other infections. "The herpes virus may be there first, the papillomavirus may come later, and the two together may have a significant carcinogenic effect," said Dr. Maria Merino, chief of surgical pathology at NCI.

One of the most common fungal infections of the vagina is candidiasis (yeast). In the United States, approximately 13 million cases of vulvovaginitis each year are due to yeast infections, which will affect three-quarters of all women at least once in their lifetimes.

Yeast is often present in small amounts in a normal, healthy vagina, as well as the digestive tract. It is only when the organism overgrows that women experience symptoms of infection: burning; itching; white, cheesy discharge; and swelling and redness of the vaginal and vulvar tissues. Many factors may cause yeast to overgrow by either changing the pH of the vagina or by altering the vaginal flora. These include antibiotic use, hormonal changes such as those that occur during pregnancy or oral contraceptive use, and systemic disease such as uncontrolled diabetes. "It's a question of what comes first—the hen or the egg," Mardh said. "Is it the change in the pH that facilitates change of the flora, or does the change in flora change the pH? There is no straight answer."

Although yeast is not necessarily sexually transmitted, some studies indicate that in some cases it can be, noted Dr. Benson Horowitz, associate clinical professor of ob/gyn at the University of Connecticut School of Medicine and conference cochair. In one study, 15 percent of the male sexual partners of women with yeast infections had positive oral, rectal and seminal cultures, indicating that women with recurrent infections may be getting reinfected by partners. For unknown reasons, however, yeast is only symptomatic in the vagina.

A number of vaginal creams and suppositories are used to treat vaginal yeast infections, usually successfully. Some women, however, have recurrent infections that do not respond well to standard treatment. Experts now believe that these women may be suffering from different strains of yeast that were previously relatively uncommon, including *Candida tropicalis* and *Candida glabrata*. Both of these strains are more resistant to standard treatment than the historically more common *Candida albicans*.

Self-help remedies such as eating yogurt have traditionally been suggested by some physicians, the theory being that the live bacterial cultures in the yogurt will help restore

the healthy vaginal flora. According to Horowitz, however, eating yogurt to cure a vaginal yeast infection may do more harm than good. "Yogurt feeds yeast," he said. "Lactose is a wonderful food for yeast. I don't know why you'd want to feed your weeds and give them weed-killer at the same time."

Another common cause of infective vulvovaginitis is *Trichomonas vaginalis* ("trich"), an STD that may cause discharge, itching, redness, pain and odor, or no symptoms at all. Antibiotic treatment is usually successful in curing the disease.

Allergic reactions to chemical irritants also may cause vulvovaginitis. Some common sources of irritation are deodorant sprays; tampons; sanitary pads; colored or perfumed toilet paper; bubble bath; laundry detergent; tight clothing; synthetic clothing (i.e., bathing suits); swimming pools and hot tubs.

While vulvovaginitis is not always sexually transmitted, the seriousness of STD-related infection—especially in the age of AIDS—cannot be overemphasized. Said Thomason: "I think we have to educate young, sexually active people that they cannot only acquire BV, herpes or HPV, but also the human immunodeficiency virus. We have to take responsibility for that with both patients and their partners." □



The PHS grant application revision committee (PHSAEC) has been busy the last year revising the Application for PHS Grant (PHS 398), the Application for Continuation of a PHS Grant (PHS 2590), and other PHS forms used by applicants applying for NIH and other PHS extramural funding. Barbara Wassell, PHSAEC executive secretary, and Dr. Nathan Watzman, PHSAEC chairperson, are shown with the clearance package for the PHS 398 and 2590 documents as the documents leave DRG. Final clearance will be through the Office of Management and Budget. It is anticipated that the forms will be ready for distribution to grantee business offices throughout the country in early 1992.

NIAID Funds Asthma Study

The National Institute of Allergy and Infectious Diseases has awarded eight grants to fund the National Cooperative Inner-City Asthma Study.

Investigators at eight institutions in Baltimore, Chicago, Cleveland, Detroit, New York City, St. Louis and Washington, D.C. will receive altogether approximately \$2.5 million for the initial year of the 5-year study.

The goal of the study is to design, implement and evaluate a comprehensive intervention program to reduce recurrent asthmatic episodes and asthma-related deaths among African-American and Hispanic children, ages 4 to 11, living in the inner city. The study sites will attempt to identify factors contributing to the increased incidence of asthma in these children. Each site will then implement therapeutic, educational and environmental programs designed to alter those factors identified as major contributors.

Asthma is the most frequent cause of hospital admissions for children, and also leads the list of childhood diseases causing a significant loss of time from school.

NIAID director Dr. Anthony S. Fauci said, "The knowledge we gain from this study will arm us with the tools to move closer to the goal of significantly reducing asthma-related mortality and morbidity rates."

The national cooperative study is being coordinated by Dr. Lawrence J. Prograis Jr., chief of the Asthma and Allergy Branch. Study centers include: Albert Einstein College of Medicine; Johns Hopkins School of Medicine; Children's Memorial Hospital, Chicago; Case Western Reserve University, Rainbow Babies and Children's Hospital, Cleveland; Henry Ford Hospital, Detroit; Howard University College of Medicine; Mt. Sinai School of Medicine, New York; Washington University School of Medicine. □

NIH Theatre Group Presents 'You Can't Take It With You'

On any of the first three weekends in May you can enjoy the NIH R&W Theatre Group's play *You Can't Take It With You* written by Moss Hart and George S. Kaufman. This delightful, amusing comedy is about an unconventional New York family of zany characters that will lighten your heart and lift your spirits. It will be directed by Sally Spangler.

Performances are: May 3, 4, 11, 17 and 18 at 8 p.m., and May 5, 12 and 19 at 3 p.m. in Masur Auditorium, Clinical Center, Bldg. 10.

Ticket prices are \$7 for adults, \$5 for senior citizens and \$3 for children 12 and under. The proceeds from the play will be donated to the NIH Patient Emergency Fund. □

HEALY

(Continued from Page 1)

and outside of government to develop their own systems and internal standards, to exercise their own good scientific taste in people, and to define their own scope and approaches to research in support of the health mission.

In my professional life I have been privileged to experience directly the strength of this great diversity nourished by NIH. I have been involved with Harvard, first as a medical student and presently as an Overseer. For many years I was fortunate to be a part of Johns Hopkins as a scientist, a clinician and a professor of medicine. Most recently I have had the challenge of leading the expansion of the Research Institute of the Cleveland Clinic Foundation which has included the development of successful new programs in molecular and cell biology, protein chemistry and bio-engineering, all targeted to major diseases. With these experiences I have seen how effectively the NIH can marshal the strengths and talents of many excellent but diverse institutions with quite different cultures for a common goal.

This powerful national network performing biomedical research has been developed under the watchful eye of the President and the Congress. And this development comes with full realization that the medical research we enjoy today has been built by public money and is fully accountable to the public. As the master craftsman of U.S. science policy, Vannevar Bush, wrote over 40 years ago, science cannot live by and unto itself alone.

With this magnificent model of scientific pursuit, our biomedical research enterprise has become an unrivalled success, the envy of the world, and a source of hope for every American who has ever been touched themselves or through their loved ones by the starkness and pain of illness—and that is virtually every one of us.

If you were to ask me what is the real secret to the great success of biomedicine, the answer would be very simple—namely, the gifted, talented and creative people who have been attracted, nurtured, challenged and rewarded by this uniquely American biomedical research enterprise. But here too lies our vulnerability: “Nothing can fail like success.” There is currently a widespread perception that biomedical research is at risk for failing, and failing in flames. You have heard these concerns in testimony this past year as never before. The science community is demoralized, and their moans are frightening off the young. There is discord on many university campuses where working scientists are pitted against administrators, basic scientists against clinical scientists, and even the Institute of Medicine is battling with the Federation of American

Societies for Experimental Biology (FASEB). Added to this discord, “scientist bashing” has become a favored pastime, and the public can only be dismayed by the reports of scientific misconduct, deceptions, conflicts of interest, and failure to deliver on time.

Things are so bad, some have said that they couldn’t even get a man to be NIH director.

With this state of affairs I come before you with both pride and humility as the nominee of President Bush and Secretary Sullivan to assume the directorship of the National Institutes of Health. And, despite the problems, I come before you with a tempered sense of optimism that this is not only a job enormously worth doing, but also one that can be done. But a lot needs to be done—and no one woman, or man for that matter, will be able to do it right without a lot of support—support from the Congress, the White House, the Secretary who has a major commitment to NIH; support from the research institutions, from the working scientists, and importantly, from the public. The public has to rediscover the NIH in its splendor and not take what it brings to them for granted; the biomedical researchers must regain faith in a system in which excellent research will be supported; our research institutions must thrive but recognize that they too must be fully accountable; and the Federal government and its many participants, at either end of Pennsylvania Avenue and in Bethesda, must be wise and steady in their judgments on behalf of the NIH, for now and for the future.

“Energetic and irreverent youth must thrive along with the older and wiser heads.”

—Dr. Bernadine P. Healy

We must start with a framework, an articulation of principles that we all can agree on, as we plot a strategy for success of the NIH. Without going into great detail, and mindful of the magnitude of the issues that will not be served by oversimplification, let me list a few guide posts as I now see them.

The first and foremost priority for a successful NIH is its human talent base. The quality of our science is no better than the quality of our scientists. We have an obligation to nourish that talent base not because they are entitled to it or because they always behave so well, but because it is the only way to fulfill our goals for a healthier world. There was a lesson for science in the play *Amadeus*. We saw

the magical, brilliant, gifted Mozart creating masterpieces, his genius effortless; but we saw him also as difficult, childish, nasty, and unconventional. His rival Antonio Salieri was a much easier-going fellow, talented in a workmanlike way and popular at court; he would likely have fared better than Mozart in today’s equivalent of a peer review system. But if medicine is to succeed, the Mozarts must be allowed to flourish. Our talent base must be diverse. Energetic and irreverent youth must thrive along with the older and wiser heads. Since science is all about brain-power, not brawn or pedigree, it must attract gifted individuals of all types. Talented women and minorities should view careers in biomedical research as the essence of equal opportunity, not just because that is proper, moral and legal, but because science needs their brains, their perspectives, and their contributions.

The talent base for biomedical research must also be multidisciplinary. The clinical investigator is as important to our goals as is the basic scientist. The newly discovered molecule must have a meaning which is learned by the physiologist or pathologist and put to good use at the bedside by the clinical scientist. Epidemiology, biostatistics, bioengineering, and biobehavior are as important as biochemistry and molecular biology, and vice versa.

The hub of the research system is its scientists, but the support systems surrounding them must also be kept healthy. As in any enterprise, financial underpinnings must be reasonably stable. Financial stability means not just having money, but how wisely and well that money is spent. I believe the cost management plan being developed by NIH under Congressional mandate is extremely important and may need to go even further than what has been outlined so far.

Peer review is another support system that must be healthy. We have appropriately delegated to peer review most of the authority for the selection of the scientists who will succeed. We must be sure that peer review is above reproach, without conflict of interest, including competitor interest, always objective and fair, and also sufficiently wise so that the unconventional Mozarts fare as well as the journeymen Salieris.

Biomedical researchers—about 95 percent of them—work in nonfederal employment, and are dispersed within the diverse and varied network of universities, colleges, research institutes, and industrial laboratories. The health of these institutions ultimately determines the health of scientists, the quality of their work, and the generation of future talent. Virtually all federal policies that affect the biomedical research enterprise—whether dollars, directives, guidelines, or laws—have an impact on the institutions conducting

research and teaching. These institutions must be partners in the policy-setting dialogue.

I have focused on the scientific talent base—the human talent factor. But there is another human factor which is every bit as important—that is the public factor. Whatever we do in science is ultimately in the context of society; whatever we do in biomedical research must be in the interest of the public. With this perspective, we might list some public interest principles.

The first is long-term planning. As a mature agency, NIH needs a long-term plan that lives beyond immediate interests. Its priorities must be identified, its attainable goals defined, and both must be sensitive to changing public need. NIH is as much about today as it is an investment in the patients of tomorrow. A long-term plan also imparts a needed stability and predictability to the enterprise.

A second public interest principle is that the NIH be a leader in areas of public trust. We must be aggressive in promoting good scientific conduct and in dealing with problems of scientific misconduct. This emphasis is not because the problems are so widespread, but more because just a few visible problems can erode the public trust for the entire enterprise. The NIH must also vigorously lead in setting research priorities in the interest of the public. For the most part, NIH has done this well, often with some nudging from the Congress. One salient example of where NIH needs to be better is in the area of research on women's health. This is an area of particular interest to me and also, as you know, to Secretary Sullivan. Women's health research has been neglected in many areas and at times outright disregarded. That is changing, in part because it was truly embarrassing to many when it finally caught their attention, but mainly because it is the right thing to do scientifically and is in the public interest.

A third public interest principle is technology transfer. If we are ever to realize the mission of NIH, technology transfer must work. The discoveries of the laboratory must be carried to the bedside, and the development of new drugs, devices, and diagnostic tests needs to be done in partnership with industry. The Federal government has developed a strong legislative portfolio over the past decade to foster that transfer. As in any new venture, the implementation has uncovered some real or perceived problems with the partnerships and their incentives. But those difficulties are not a reason to walk away from a principle of great social value; they provide an impetus to develop carefully crafted guidelines to help industry, academia and government work together for the right reasons and not be tarnished by even a hint of wrong ones.

A final public interest principle that I would like to articulate is one that concerns

the interface of science and social policy. I firmly believe that much of the success of science in this country is that it has largely been nonpolitical and nonpartisan. It has been allowed to thrive by the objective pursuit of truth. That must continue. But there are circumstances that arise where the moral or ethical concerns of the society may appear to collide with the pursuit of science. History has shown us that most often, science proceeds but within a certain framework defined by public interest. This is the history of recombinant DNA research and the oversight of the NIH recombinant DNA committees. This is the history of institutional review boards for overseeing any medical research which involves human subjects. This is the history of guidelines for the humane treatment of animals in research, and the creation of animal care committees. The same principle underlies the plans of the human genome project to invest part of its resources into studies of the ethical implications of knowing a person's genetic makeup. As we move ahead, these approaches should serve as models for assuring the public that science indeed does not live by and unto itself alone, but in the service of man and womankind.

Allow me to close with a personal anecdote. I happen to be a student of taxicab driver wisdom. A few years ago I was in a cab from LaGuardia Airport enroute to a cardiology meeting in New York. As we were coming to the Queensboro Bridge in Long Island City, I mentioned to the driver that I had grown up only a few blocks from that very bridge in a little Italian neighborhood. When I got off in downtown Manhattan near the meeting, the cab driver turned around and very sweetly said, "Hey doc, don't ever forget where ya come from." As I look to directing the NIH, I plan not to forget. I come from a world of hard-working biomedical scientists; men and women who are intent, dedicated, sometimes failing, often succeeding, but always caring very much about their life's work. But I also come from the bedside. I have shared the pain of disease, the struggle of recovery, and the finality of death with my patients and with their families. I hope never to forget that I am still working for them. □

Financial Planning Seminar Set

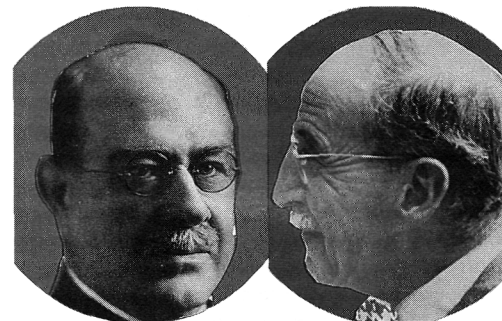
The NIH Federal Credit Union will present a financial planning seminar that will focus on the following topics: last minute 1990 tax tips; money management and investment opportunities; college funding.

The seminar will take place on Apr. 5 from 11:30 a.m. to 1:30 p.m. in Bldg. 31C, Conf. Rm. 8.

Those interested in attending should call Kathy McPherson by Apr. 4 at (301) 881-2750. □

DIRECTORS

(Continued from Page 1)



Dr. Joseph J. Kinyoun Dr. Milton J. Rosenau

laboratory would someday attain the size and scope of today's NIH.

Born in North Carolina in 1860, Kinyoun completed his medical training at New York University and joined the Marine Hospital Service, the precursor of the Public Health Service, just as the germ theory of disease was revolutionizing medicine. He studied the techniques of bacteriology in New York, and because of this special training, he was the officer selected in 1887 to establish a laboratory at the Marine Hospital on Staten Island, N.Y.

The young Kinyoun—he was only 27—called his facility a "laboratory of hygiene," the name styled after the German "institute of hygiene" and reflecting German leadership in bacteriology. In 1891 the laboratory moved to Service headquarters in Washington, D.C., and, gradually, it became known as the Hygienic Laboratory. During Kinyoun's years as director, it remained a small facility, with Kinyoun the chief staff member and one or two other Service officers assisting him from time to time.

Kinyoun organized a training course in bacteriological methods for young physicians in the Service. He did virtually no basic research, but he was called upon for bacteriological analysis of water in the District of Columbia (most wells were contaminated, he found) and designed sterilizing equipment for disinfecting ships.

In 1899, Kinyoun fell from favor with Surgeon General Walter Wyman and was replaced as director. He was sent to San Francisco, where in 1901 he identified an outbreak of bubonic plague. Although the political and economic leadership of San Francisco challenged his finding because of its potential economic impact, it was confirmed by an independent commission of leading public health figures.

In 1903 Kinyoun retired from government service. He subsequently headed the H. K. Mulford laboratories and served as chairman of the pathology department at George Wash-

(Continued on Page 8)

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ington University and as bacteriologist for the District of Columbia health department. He died on Feb. 14, 1919.

Dr. Milton J. Rosenau, 1899-1909

Chosen to replace Kinyoun was 30-year-old Dr. Milton J. Rosenau. The Philadelphia native studied medicine at the University of Pennsylvania and did postgraduate work in sanitation and public health at the leading European research centers Berlin, Paris, and Vienna. He was commissioned into the Marine Hospital Service in 1890. A bright young officer with a keen interest in research, Rosenau had assisted Kinyoun on numerous occasions.

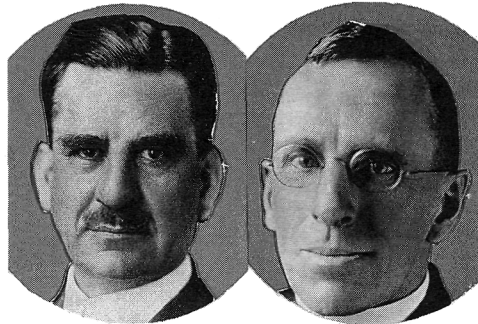
Rosenau left an indelible mark on the Hygienic Laboratory, for it was during his tenure that the formal research program of the Hygienic Laboratory was launched. In 1902, Congress reorganized and expanded the Hygienic Laboratory and renamed the Service "Public Health and Marine Hospital Service." From a one-man facility, the laboratory grew into a full-fledged organization with its own building and three new divisions: chemistry, pharmacology, and zoology. Rosenau hired leading scientists to head these divisions and gave them considerable freedom to conduct research. He himself directed the Division of Pathology and Bacteriology and enforced the regulatory responsibilities mandated by the 1902 Biologics Control Act to ensure the purity and potency of privately manufactured antitoxins and vaccines.

With his successor, Dr. John F. Anderson, Rosenau conducted pioneering research on anaphylaxis—the acute, sometimes fatal allergic reaction caused by a substance to which a person is hypersensitive. He also supervised a major study of typhoid fever in the District of Columbia and investigated bacterial contamination of milk—efforts that had widespread implications for the nation's health.

In 1909 Rosenau resigned from the Service to become professor of preventive medicine at Harvard Medical School. In 1935 he moved to the University of North Carolina to help found its school of public health. His textbook *Preventive Medicine and Hygiene* became a standard text for students of public health. Rosenau died in 1946.

Dr. John F. Anderson, 1909-1915

Born in Fredericksburg, Va., in 1873, John F. Anderson took his M.D. degree at the University of Virginia, after which he traveled to Europe to learn from the leading research scientists. He studied bacteriology in Vienna, in Paris, and at the London School of Tropical



Dr. John F. Anderson Dr. George W. McCoy

Medicine in Liverpool. He joined the Service in 1898 upon his return and rose rapidly to assistant director of the Hygienic Laboratory. He was named director in 1909.

Anderson collaborated with Rosenau on several important studies, and he worked with Dr. Joseph Goldberger in establishing monkeys as an animal model for studying measles. In 1912, Congress again shortened the name of the Service—it became simply the "Public Health Service"—and expanded the Hygienic Laboratory's authority to conduct research, this time into noninfectious diseases.

Anderson resigned from government service in 1915 to become director of the research laboratories and later vice president of E. R. Squibb & Sons. He died in 1958.

Dr. George W. McCoy, 1915-1937

In 1915, Dr. George W. McCoy was named director of the Hygienic Laboratory. He served for 21 years—the longest tenure of any NIH director.

A Pennsylvania native of Scottish descent, McCoy was born in 1876 and took his M.D. from the University of Pennsylvania Medical School. He joined the Service in 1900 and was sent to San Francisco, where he became interested in leprosy. He subsequently became the undisputed U.S. authority on that disease. From 1908 to 1911 he directed the U. S. Plague Laboratory in San Francisco and, during one field study, he identified a new "plague-like disease" in California ground squirrels that was later shown to infect humans and named "tularemia" after the county in which it was first identified.

During his tenure as director, Hygienic Laboratory researchers addressed health threats to Allied forces during World War I and treated patients in the District of Columbia during the influenza pandemic of 1918. In 1930 the Laboratory was renamed the National Institute of Health, and, with the passage of the Social Security Act in 1935, funding and staff for the NIH increased significantly.

McCoy was highly regarded for providing intellectual freedom to his staff, and he continued active research while discharging his

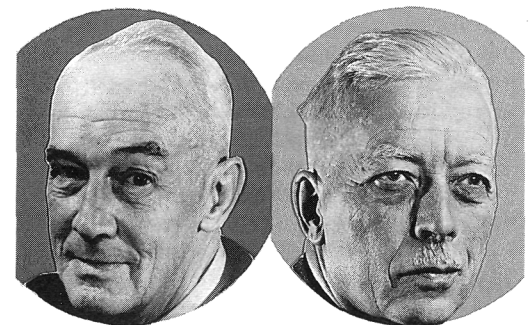
administrative duties. He was also known to be extremely frugal with taxpayer's money—his office was small and sparsely furnished, and he demanded strict accounting of expenditures by his staff. He never learned to drive an automobile.

A conservative Republican, McCoy did not share the vision of an expanded NIH that Surgeon General Thomas Parran hoped to implement. He was thus replaced as director in 1937 by Dr. Lewis R. Thompson. After conducting a nationwide study of leprosy for the Service, McCoy retired in 1938 and became professor of public health and preventive medicine at Louisiana State University in New Orleans. He died in 1952.

Dr. Lewis R. Thompson, 1937-1942

Overseeing a major period of expansion for the NIH became the responsibility of Dr. Lewis R. Thompson. The Indiana native, born in 1883, helped to acquire the estate of Mr. and Mrs. Luke I. Wilson in Bethesda, Md. He oversaw construction of the first six buildings and supervised as the NIH staff moved for the first time since 1904, from 25th and E Streets, NW, in Washington, D.C., to the new campus in Bethesda.

Thompson graduated from Louisville Medical College and joined the Service in 1910. His major research interests were in the problems of stream pollution and industrial hygiene. He was especially well-known for



Dr. Lewis R. Thompson Dr. Rolla E. Dyer

publications on the health of workers in the dusty trades.

In 1930 he was appointed chief of the Division of Scientific Research, and his administrative talents as a legislative liaison were used to good effect as the Service struggled to maintain programs during the Great Depression. When his division was merged with the National Institute of Health, he became NIH director. Another major administrative change transferred the Public Health Service out of the Treasury Department, where it had been since 1798, to the newly created Federal Security Agency.

Both Thompson and Surgeon General Thomas Parran believed that the NIH was destined to expand. One immediate need was

space for a farm on which experimental animals might be raised. When Mr. and Mrs. Wilson offered 45 acres of land to the government to be used "for the general good of the people of the country," Thompson seized the opportunity to provide all of NIH with growing space, and he secured the Wilsons' support for moving the entire Institute to Bethesda. In subsequent years, they increased the size of their donation, ultimately providing 90 acres of the present NIH campus.

In 1942 Thompson was transferred to head the newly established Bureau of State Services, a post he held until retirement in 1947 for physical disability. Thompson died in 1954.

Dr. Rolla Eugene Dyer, 1942-1950

The director who led NIH through most of World War II and oversaw the creation of the modern structure of the agency was Dr. Rolla E. Dyer. Son of an Ohio clergyman, he received his M.D. from the University of Texas Medical Branch and joined the Public Health Service in 1916.

Dyer rose rapidly through Service ranks and joined the Hygienic Laboratory in 1921. Within a year, he was named assistant director. An expert in infectious diseases, Dyer was best known for his work on rickettsial diseases. In 1931 he identified the existence of Rocky Mountain spotted fever on the East coast and demonstrated that fleas were the vectors of murine typhus. In 1936 he became chief of the NIH Division of Infectious Diseases and served in this capacity until being named NIH director in 1942.

During World War II, Dyer supervised NIH research on typhus vaccines, blood transfusion methods, high altitude physiology, and other war-related problems. In the expansive post-war period, he oversaw the creation of the NIH grants program and the establishment of institutes to study heart disease, mental health, and dental diseases. Existing divisions of the National Institute of Health were organized into freestanding institutes and the overall name of the agency was made plural: National Institutes of Health. The Clinical Center was also planned under his administration. For his contributions, he received a Lasker Award in 1948.

In 1950, Dyer retired and became director of research at the Robert W. Winship Clinic at Emory University in Atlanta. He died in 1971. □

NIH Training Center Catalogs

NIH Training Center catalogs and brochures are located in racks:

- Bldg. 10, 1st floor near cafeteria
- Bldg. 10, 2nd floor near cafeteria
- Bldg. 31, B2B47 inside URC
- Bldg. 31, B1B level near elevator
- Westwood, outside Rm. 438. □

Savings Bond Drive Begins, Apr. 16

May 1, 1991, marks the 50th anniversary of the introduction of the Series E Bond, the start of the modern Savings Bond program. The anniversary logo summarizes the Savings Bond theme for 1991: "Celebrate An American Tradition—50 Years of U.S. Savings Bonds." NIH'ers can participate in the kickoff of the NIH U.S. Savings Bond campaign Apr. 16, on the patio of Bldg. 31A at 12 noon.

The story of the Savings Bond Program has many facets. But its most distinguishing characteristic is that—through the volunteer efforts of labor organizations and the commitment of employers to the payroll savings program—U.S. Savings Bonds have become an American tradition.

Setting the scene for the program was the start of World War II in Europe and the need for the U.S. government to raise funds for defense preparations. On Apr. 30, 1941, President Franklin D. Roosevelt went on the air to announce a new "Defense" Savings Bond, the Series E, and invited all citizens to join him in "one great partnership" to help finance the nation's defense effort. On May 1, he pur-



chased the first Series E Bond from Secretary of Treasury Morgenthau.

A skeleton headquarters staff in Washington was set in place and a field organization was put together, state by state. A leading businessman or banker became volunteer state chairman and community leaders throughout the state became county chairmen. Together, they comprised a massive volunteer program that involved almost every segment of the population—businessmen, bankers, teachers, schoolchildren, mothers, fathers, grandparents, organized labor, farmers, ethnic groups, civic organizations, stars of stage, screen and radio, as well as authors and artists, civilian and military workers. Payroll savings plans, already used by business and industry to enable employees to buy company stock or to pay insurance premiums, were instituted for Savings Bonds.

Tools of the trade for promoting Savings Bonds were a little less sophisticated—there was no television, no computer, no fax machine. But what promoters lacked in equipment was compensated for in creativity. Skaters in an Ice Capades act carried Savings

Bonds. In Oklahoma, "General Grant," a registered Hereford bull, brought in \$1,850,000 worth of bonds during auctions. King Neptune, the million-dollar pig from Franklin County, Ill., was sold once with proceeds paid in bonds. In Worcester, Mass., a gentleman dieted for bonds. The money he saved on candies, cakes and other forbidden foods was used to buy Savings Stamps.

Unlike today, bonds were sold everywhere—at sidewalk booths, post offices, at theaters, in door-to-door campaigns. They were sold over the counter, through payroll savings plans, and through schools and all kinds of national, civic, and fraternal organizations.

Bonds have changed over the years, but the program still depends on the voluntary efforts of many dedicated individuals who work hard to explain the many features and benefits of Savings Bonds—including the tax exclusion for bonds used for higher education. For many Americans, only a regular savings program, in place today, will make higher education for their children a reality tomorrow.

As the U.S. Savings Bonds program begins its 50th anniversary year, Americans can take pride in knowing that their efforts perpetuate a program that helps make the future brighter not only for bond buyers but for every citizen.—Carol Cronin □

Diabetes Update Day Planned

Researchers and caregivers are welcome to attend the Diabetes Update on Saturday, Apr. 20, from 9 a.m. to 5 p.m. in Lipsett Amphitheater, Bldg. 10. Among the topics to be discussed are diabetes in relation to hypertension, aging, and obesity as well as disordered immunity in insulin-dependent diabetes, use of insulin and sulfonylureas, and diabetic neuropathy.

The update is sponsored by the Diabetes Branch, NIDDK, and the D.C. area affiliate of the American Diabetes Association. Six hours of CME or CEU credits are available.

For a registration form or more information, call Ms. V. Katz, 496-8090. □

Open House for Bike Club

All are welcome at the NIH R&W Bike Club's spring open house, Wednesday, Apr. 17 from 5:30 to 8 p.m. at the FAES House. There will be speakers, videos, ride sign-up, door prizes and refreshments. Admission is \$2 for nonmembers, \$1 for members, and Bike Club memberships (for \$2) will be available at the door. For more information, call Jay Miller, 496-6941. □

NIDR Epidemiologist James Carlos Retires

Dr. James P. Carlos, chief of the Epidemiology Branch in the Epidemiology and Oral Disease Prevention Program, NIDR, retired Feb. 1 after 23 years with the institute.

Carlos came to NIDR in the late 1960's as part of an effort by Dr. Seymour Kreshover, then NIDR director, to recruit scientists who would conduct applied research for the institute. Carlos joined NIDR's biometry section in 1967. In 1970 he became a branch chief, heading the Disease Prevention and Therapeutics Branch.

In 1972, Carlos was appointed NIDR associate director for the National Caries Program (NCP). The NCP sought to eliminate dental caries—tooth decay—as a major health problem. It was the first targeted research program at NIDR, and the first program at NIH to combine intramural and extramural research under one management.

"The National Caries Program was certainly one of my major efforts at NIDR. We built it from scratch," said Carlos. "We like to think we accomplished something." The NCP succeeded in promoting topical fluoride applications through school-based mouthrinsing; it was responsible for the development of better dental sealants; and it funded research that advanced the understanding of the microbiologic, immunologic and dietary causes of dental caries. Carlos served as head of the NCP until 1983, and then as associate director for the Epidemiology and Oral Disease



Dr. James P. Carlos

Prevention Program, which followed the NCP. Since 1986 he has served as chief of the Epidemiology Branch.

Carlos received a D.D.S. from Temple University School of Dentistry and an M.P.H. from Columbia University School of Public Health and Administrative Medicine. Prior to joining NIDR, he was with the State Health Department in Albany, N.Y.

Carlos acknowledges he will miss the people and the work at NIDR, but is looking forward to retirement. He and his wife are moving to Naples, Fla., where he plans to "do some boating and fishing." Other retirement plans include traveling in Europe. □

Dry Mouth Not Linked to Menopause

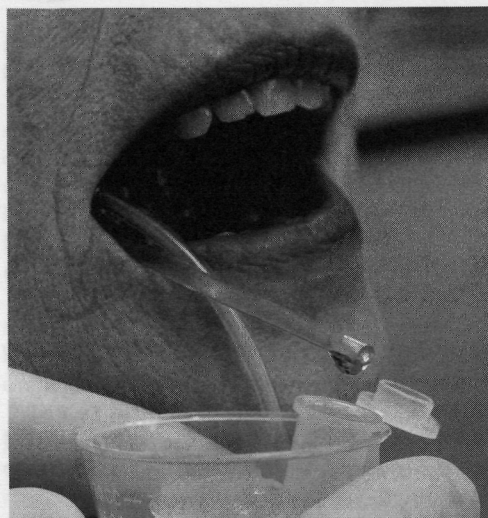
A new study shows that if you are over 50 and have mouth discomfort such as dryness or burning, it may have nothing to do with menopause or the hormone replacement therapy some women undergo for years afterwards. This study contradicts what many doctors have long believed about menopause.

Dr. Jonathan Ship and his colleagues at NIDR studied 43 healthy women between the ages of 35 and 65. Fifty is the average age of menopause.

Twenty-two of the women had not yet reached menopause, and 21 were postmenopausal. None of the subjects were taking any medications except eleven of the postmenopausal women who were receiving hormone replacement therapy.

The scientists queried the women about oral dryness or other types of discomfort in their mouths, and measured how much saliva they were producing.

Results showed no significant differences in either the amount of oral discomfort reported or saliva production between the two groups of women. Also no differences were found between the postmenopausal women who received hormone replacements and those who



A patient donates saliva for a study of dry mouth. did not.

Feelings of dryness or burning in the mouth sometimes can be caused by illness or reactions to certain drugs. So if a woman has gone through menopause and is having oral problems, she should make sure her physician looks for other causes.—Sandra D. Levine □

Sports Injuries in Youth Subject of NIAMS Workshop

Each year, sports injuries in young people exact a high physical toll and substantial financial costs. A national surveillance program for sports injuries could provide data needed to develop improved strategies to control or curtail many of these problems. To address optimal ways of developing such a program, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Advisory Board, and the Centers for Disease Control are convening a workshop, "Sports Injuries in Youth: Surveillance Strategies," to be held on Apr. 8 from 8 a.m. to 5 p.m. and on Apr. 9 from 8 a.m. to 12:30 p.m., at the Lister Hill Center, Bldg. 38A.

The invited participants include orthopedic surgeons, coaches and trainers, representatives from state public health departments, epidemiologists, and other interested parties. There is a \$10 registration fee. For registration information, contact Connie Herndon, (301) 468-6555. □

ECS Lectures Continue

The Employee Counseling Services Guest Lecture Series will continue with a presentation by Dr. Dale Berman, on "Anger in the Workplace." The presentation will be given on Thursday, Apr. 11 in Conf. Rm. 4, Bldg. 31 from noon to 1 p.m. A two-part film presentation, *How To Speak Up, Set Limits, and Say No*, will be offered on Thursday, Apr. 18 (part 1) and Thursday, Apr. 25 (part 2) in the Little Theater, Bldg. 10 from noon to 1 p.m. For information call 496-3164. □

'Bike to Work' Day Planned

In celebration of Earth Day, the NIH R&W Bike Commuter Club is sponsoring "Bike to Work Day" on Sunday, Apr. 21 beginning at 10 a.m. The bike club would like to introduce NIH'ers to the pleasure of bike commuting. Experienced commuters will lead groups of people interested in commuting to the NIH campus from various points in the suburbs. All are welcome. For more information, call Cindy Walczak, 496-9750. □

FDA Seeks Volunteers

FDA/NIH is seeking volunteers who are allergic to latex or rubber to participate in a study involving blood donation and allergy skin testing. Also needed are volunteers who are allergic to trees and experience spring hay fever to participate in a study involving blood donation and allergy skin testing. Participants will be paid. Send written requests to Jackie Matthews, Bldg. 29, Rm. 201. □



TRAINING TIPS

The NIH Training Center of the Division of Personnel Management offers the following:

Courses and Programs Starting Dates

Management and Supervisory 496-6371

Creativity with and through Groups	4/17
Hands-on Animal Rodent Techniques	4/24
Working With Personal Differences MBTI	5/1, 5/15
Presidential Operations Workshop	5/6
Interacting With Difficult Employees	5/7
Managing Workforce Diversity:	
Skills for Utilizing Differences	5/8
Managing Stress	5/14
Efficient Reading	5/29

Personal Computing Training 496-6211

Welcome to Macintosh	5/3
Intro to WordPerfect (Mac)	5/6
Intro to Microsoft Word (Mac)	6/5
Excel Level 1	5/9
Excel Level 2	5/16
FoxBase (Mac) Level 1	5/13
Hypercard Programming: Level 1	5/7
Intro to Personal Computing for New Users	5/1
PC Keyboarding: Intro	5/3
WordPerfect 5.1	5/6
Intro to DOS	5/6
Harvard Graphics, Rel. 2.3	5/1
DBase III: Intro	5/8
Lotus 1-2-3, Rel. 2.2 Intro	5/13

Office Operations and Administrative 496-6211

Effective Guide to Good Grammar	4/22
Introduction to Working at NIH	4/29

User Resources Center 496-5025

Self study hands-on Personal Computer tutorial courses are available to NIH employees at no cost.

Rapp Gives Chaos Talk

The fourth talk in the listener-friendly series on chaos and fractals will be given by Dr. Paul E. Rapp of the department of physiology and biochemistry, Medical College of Pennsylvania. The title is "The Nonlinear Brain from Epilepsy to Cognition: Analysis of Neural Spike Trains and EEG Time Series."

Rapp pioneered "listener-friendly" communication about nonlinear dynamics and chaos theory through his participation in the *Nova* TV production entitled, "The Strange New Science of Chaos."

The talk will be given Friday, Apr. 12 at 2:30 p.m. in Lister Hill Auditorium, Bldg. 38A. □

Complaints About Vendors?

The Division of Procurement (DP) recently established a system whereby NIH staff can register their complaints about a vendor's performance. Problems with vendors who have blanket purchase agreements (BPAs) should be directed to Donald Kemp, Bldg. 31, Rm. 3B59, 496-5212. Complaints about non-BPA vendors should be directed to Douglas Swank, Bldg. 31, Rm. 3B58, 496-4814.

Although NIH staff may voice their complaints by telephone, written information is needed to resolve any problems. The NIH Quality Improvement Report form should be completed and forwarded to DP. This form is available from ICD administrative offices. □

BPA Equipment Limits Raised

In January, the Division of Procurement increased the authority to purchase equipment from mandatory Federal Supply Schedule contractors with blanket purchase agreements (BPAs). Through DELPRO, an ICD ordering office may now purchase up to \$5,000 worth of equipment per order. To make it easy to identify these vendors, the NIH-wide BPA listing has five new equipment categories. Currently, ADP and telecommunications hardware and software purchases as well as all open market equipment purchases using BPAs remain at \$1,000 per order regardless of the BPA's order limitation. Vendors are not authorized to sell equipment unless the BPA is coded for equipment. NIH employees should contact their administrative officer for a copy of the NIH-wide BPA listing showing the equipment commodities and vendors. □

Procurement Assistance Provided

Procurement advice and assistance for purchases under \$25,000 is available by calling the Small Purchase Helpline (formerly the DELPRO Helpline). Between 8:30 a.m. and 5 p.m. daily, NIH employees can call 496-0400 to obtain complete, accurate and consistent answers to procurement questions or problems related to entering orders into the Administrative Data Base. Questions may also be faxed to the Helpline staff on 480-5302.

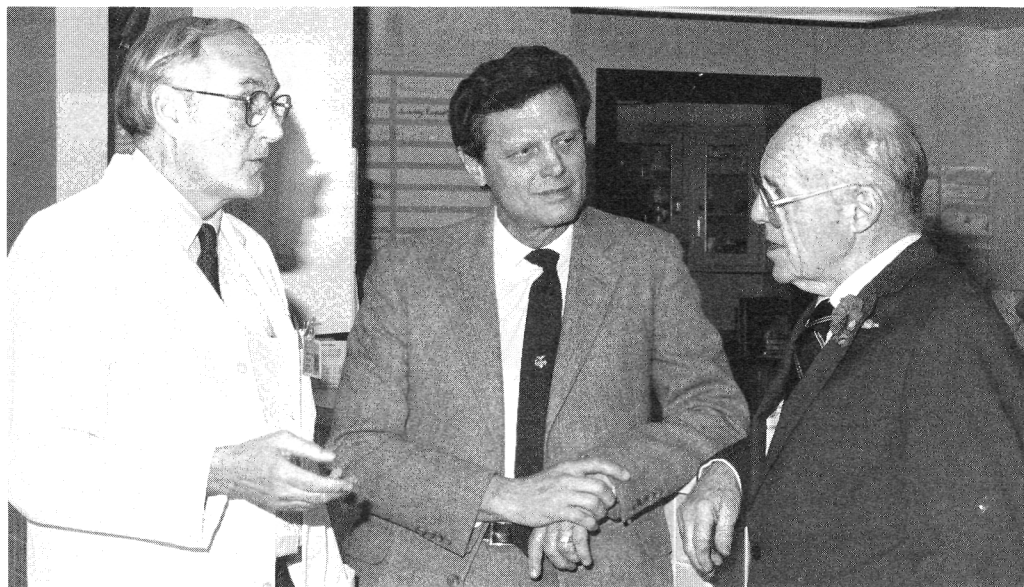
To obtain status information on requisitions submitted to the Division of Procurement (DP), the PRV function in DELPRO should be used. If you need to talk about a procurement being processed by DP, you may call the purchasing agent assigned to the requisition. □

Accelerated Purchase Limits Raised

In January, a revised accelerated purchase system (APR) was instituted as a result of changes to the Federal Acquisition Regulation. The threshold for submitting APRs was increased from \$1,000 to \$2,500 per order. This change may result in an additional 5,000 orders being processed through the APR system. The APR continues to be a quick turn-around mechanism to purchase supplies and services that cannot be obtained through existing BPA vendors. □

Research Volunteers Needed

The Laboratory of Neurosciences, NIA, seeks volunteers to participate in a study investigating the effects of aging on brain functions. Volunteers must be medication-free and without past or present major health problems. Those under age 30 and above age 60 are particularly needed. Procedures require approximately 13 hours; participants can receive a stipend of up to \$300. For information call 496-4754. □



Dignitaries from NIH and Research!America—an Alexandria-based coalition dedicated to educating Congress, key constituency groups, and the general public about the need for federal support of biomedical research—were participants at the recent 28th anniversary of the General Clinical Research Center (GCRC) at the University of Vermont (UVM) in Burlington. Listening intently to Edwin C. Whitehead (r), chairman of the board of Research!America, are Dr. Robert A. Whitney Jr. (c), NCRR director, and Dr. Elliot Danforth, GCRC program director at UVM. The NCRR supports a nationwide network of 74 GCRCs, all of which are located in major medical centers. Investigators using GCRCs receive approximately 85 percent of their primary research support, which now totals almost \$1 billion, from NIH categorical institutes and ADAMHA.

Westwood Facility Opens

NIH Credit Union Branches Out

By Carla Garnett

It has been a long time coming, but on Feb. 25 NIH'ers in the Westwood Bldg. finally got what they deserve: The NIH Federal Credit Union opened its branch on the ground floor of 5333 Westbard Ave. The grand opening Mar. 15 drew more than 550 people in an hour and a half.

"This was in the works before I arrived here," said Lindsay Alexander, credit union president and chief executive officer since July 1989. Plans to develop a branch at Westwood were initiated about 3 years ago, she said, but the project kept changing hands and getting postponed.

Alexander said although she is not yet sure what traffic will be like at the new facility, she hopes the convenience of the Westwood branch will attract new members.

"I know for a fact that there are employees in Westwood who do not have accounts with us," she said, adding that the more than 1,000 NIH employees working in the building justify opening the branch. "It just wasn't convenient for them to have to come to the main campus every time they needed to use the services. We expect that with this new branch we'll see an increase in membership."

Currently, 386 Westwood employees are NIHFCU members, according to operations branch manager Norma Thorwart. Those members account for more than \$3.1 million of outstanding loans. "That shows there's a lot of business over there," said Thorwart.

The branch opening at Westwood also sends an important message to other credit union members: NIHFCU is healthy and growing.

Alexander said the recent media accounts of troubled credit unions in Rhode Island had an impact on credit union members around the country.



The NIH Federal Credit Union, which serves nearly 23,000 members, recently opened its fifth branch at the Westwood Bldg. President and CEO Lindsay Alexander, NIH acting director Dr. William Raub (c) and chairman of the credit union board of directors Dr. Harley Sheffield cut the ribbon at the branch's Mar. 15 grand opening.

"There was a reverberation nationwide," she said. "We and a lot of other unions have tried to reassure members of all the good things that they need to hear—we're federally insured and our reserve is healthy and growing. We've tried to be real attentive to the public's concerns."

Sandeep Singh, credit union marketing manager, agreed. "The National Credit Union Share Insurance Fund, which insures our credit union, is the strongest fund in existence." According to Alexander, it had the fewest number of failures in 1990.

Confidence in the credit union seems to be at an all-time high. Already NIH employees working at Executive Plaza are clamoring for their own branch too. And Alexander is considering it. The Division of Space Management projects that more than 2,000 NIH'ers will be working in the EPN vicinity by the end of this latest transition period, she said.

"You can't expect people to move over there and have no amenities," Alexander said. □

Minorities in Science Is STEP Forum Focus

"Minority Scientists: Widening The Pipeline," a forum Apr. 10 sponsored by the Staff Training in Extramural Programs (STEP) committee, will examine the educational "pipeline" from elementary through graduate school. Issues to be discussed are: factors that attract minority students to science and conditions that can cause them to drop out; critical points where barriers can arise and where interventions can have the greatest impact; and the role of historically black colleges and universities in the molding of scientists.

In addition, the speakers will discuss approaches developed at individual colleges and universities that have been successful in advancing students into graduate and professional schools.

The panel of speakers includes moderator Dr. John Ruffin, NIH associate director for minority programs; Dr. Alonzo Atencio, assistant dean for student affairs, University of New Mexico; and Dr. Norman Francis, president, Xavier University, New Orleans. The presentations will be followed by a roundtable discussion, allowing for audience participation.

The forum will be held from 1 to 3 p.m. on Wednesday, Apr. 10, in Wilson Hall, Bldg. 1. The forum is open to all NIH personnel. No advance registration is required, and attendance will be on a space-available basis. Continuing education credit is not available. For further information, contact the STEP program office, Bldg. 31, Rm. 5B44, 496-1493. □

ECS Offers Video Series

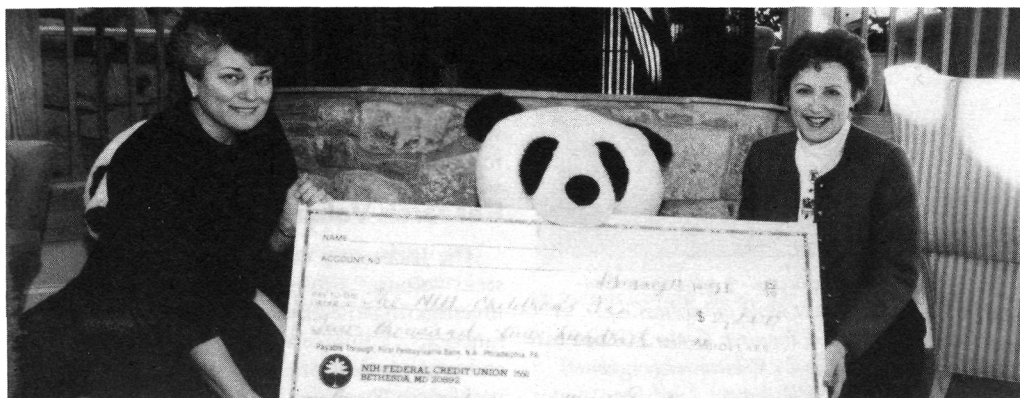
The Employee Counseling Services is continuing to present its new video series on work, career, and personal growth issues to the NIH community. The next presentation in the series is entitled "How To Set and Achieve Goals." This videotape is divided into several 50-minute segments. They will be shown on consecutive Tuesdays from noon to 1 p.m. in the Little Theater located in Bldg. 10. A question and answer session led by ECS's Dr. Michael Bowler will follow each session. The segments are as follows:

Apr. 9: Personality Style and Motivation

Apr. 16: Getting Focused

Apr. 23: Keeping Track of Goals

Look for details about the June 4, 11, 18, and 25 video series entitled "Stress Management for Professionals." Please contact ECS, 496-3164 if you have any questions about this program. □



Lindsay Alexander (r), chief executive officer of the NIH Federal Credit Union, recently presented Margo Bradford, day manager at the Children's Inn at NIH, with a giant check for some \$2,200, to be used for inn expenses. The funds were raised when the credit union donated a nickel to the inn for every transaction—of which there were some 44,000—using a credit union Visa card. The Visa promotion ran last fall.